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Testimony of Advocacy for Patients with Chronic Illness In Support of Bill Nos. 5486, 5485 and 410

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Thank you for this opportunity to present comments on Bill Nos. 5486, 5485 and 410.

Advocacy for Patients with Chronic Illness is a 501(c)(3) tax exempt nonprofit that provides free insurance and legal assistance to patients with chronic illnesses nationwide. We provide these comments based on our extensive expertise working with chronically ill consumers whose care depends in large part on insurance coverage – the one thread that runs through all three of these Bills.

Raised Bill No. 5486 would limit prescription drug coinsurance to $1000 per year for individuals and $2000 per year for families. This legislation is an appropriate response to the advent of so-called specialty tiers, pursuant to which insurers charge a percentage copay for prescription drugs used to treat chronic conditions such as Crohn's disease, rheumatoid arthritis, and multiple sclerosis. These drugs may cost thousands of dollars per month. For example, we worked with one multiple sclerosis patient whose coinsurance would have been $3000 per month or $36,000 per year – clearly more than most people can afford. Specialty tiers threaten to restrict the best health care to only the very wealthy among us. Raised Bill No. 5486 would ensure that all insured consumers have access to medically necessary care.

These are not newfangled treatments with a lot of bells and whistles; these are mainstream treatments that are used routinely to treat chronic illnesses. For example, Humira, an injectable biologic, has been FDA approved for the treatment of rheumatoid arthritis since 2003, and for the treatment of Crohn's disease since 2007. It has become standard therapy for these indications. We have worked with literally hundreds of patients whose diseases have remitted due to the use of this medication, and its continued use helps to maintain remission. Although it is expensive, without it, a patient with Crohn's disease could experience a flare that could lead to a hospitalization, surgery, a feeding tube – all of which would be far more expensive than enabling patients to access this drug with an affordable copay.

Indeed, it is our view that insurers who utilize specialty tiers are extremely short-sighted. If a patient with a serious chronic illness has found something that puts and keeps their illness in remission, their health care costs will be far lower than they would be if their

illness was allowed to flare unchecked. Most patients who take these medications already tried everything else and experienced no relief of their symptoms. They already know that the less expensive options will not work. These medications have been a godsend for those for whom they are effective. They have allowed people who otherwise would become disabled to live a full life and be productive, tax-paying members of society.

If we are going to control health care costs in America, we must ensure that patients with chronic illnesses have access to the medication that stabilizes their health and allows them to remain productive. The alternative is to allow their illnesses to run rampant, with the accompanying costs both to insurers and to society as a whole. Raised Bill No. 5486 not only protects consumers and ensures their access to medically necessary care, but it also, in the long-run, helps to control the costs of health care, thereby also benefitting insurers and society as a whole. We therefore strongly urge its passage.

Raised Bill No. 5485, on the other hand, contains some very problematic provisions. First, it forecloses Connecticut from creating a Basic Health Program. Connecticut should take advantage of the Basic Health Program option to design a program that mirrors the benefits, cost-sharing and procedural protections of Medicaid for eligible populations with incomes between 133% and 200% of the federal poverty level. Individuals at this income level will find the cost-sharing requirements in the Exchange unaffordable, even with the subsidies in the Affordable Care Act (ACA) and, thus, may remain uninsured. The Basic Health Program provides an affordable option at no cost to the state; the federal funding formula for the Basic Health Program should cover all the Basic Health Program costs, as confirmed by Mercer's report to the Health Insurance Exchange Board. Indeed, because significant numbers of Medicaid beneficiaries would be shifted off of Medicaid to the fully federally funded Basic Health Program, the BHP would save the State up to $48 million. We have submitted more detailed testimony on Raised Bill No. 5450, which authorizes the creation of a Basic Health Program, to the Human Services Committee, which held a hearing on this Bill on March 13, 2011.

Raised Bill No. 5485 also calls on this Committee to select a benchmark plan, as outlined in the Essential Health Benefits Informational Bulletin issued by the United States Department of Health and Human Services on December 26, 2011 as the standard for qualified health plans and plans sold outside the Exchange. This decision – one of the most substantive and critical decisions that must be made by States in implementing the ACA – must be made by May 8, according to the Bill. Such a critical decision should not be made this quickly, without full study and analysis, as well as public comment and participation of all stakeholders. Unfortunately, in its report to the Health Insurance Exchange Board, Mercer did not evaluate the four benchmark options; thus, this Committee would be charged with conducting such an evaluation – from the possibly diverging perspectives of consumers, insurers, health care providers, and the State – in less than two months, without an opportunity to fully analyze the consequences of this choice.

We would, therefore, urge that the Health Insurance Exchange Board, including its advisory committees, be tasked with studying the four benchmark options and submitting its analysis and recommendation to this Committee. The Health Insurance Exchange Board has the ability to consider the perspectives of all stakeholders through its advisory committees, and to retain expert consultants to assist with its study of this extraordinarily important issue. We urge this Committee to ensure that fully adequate evaluation of the four benchmark options, with input from all stakeholders, is conducted before the plan that will govern the structure of every insurance policy sold in the State of Connecticut is selected.

Finally, SB 410 makes two very important additions to the statutes governing the conduct of insurance appeals. First, it requires insurers to include copies of all documents, communications, information, evidence and rationale with notices of adverse determinations. This would make a world of difference to consumers who wish to challenge adverse determinations. Indeed, it would help consumers to understand the basis for adverse determinations so that they could decide whether or not to raise such a challenge.

In addition, this provision would eliminate the problems that have always arisen under the existing statutory language, which allows consumers to request these materials if they so choose. In our very considerable experience representing consumers in health insurance appeals, insurers typically ignore such requests. Even worse, we have had the vexing experience of having this request for documents counted as an appeal, thereby depriving the patient of an entire level of review. If consumers are to be better able to evaluate and challenge adverse determinations, this statutory change should be passed.

In addition, SB 410 provides that, when an insurer denies coverage of a prescription drug and the consumer appeals, the insurer must authorize coverage of the drug during the pendency of the appeal. Not only would this provision encourage insurers to process appeals on a timely basis, but it will ensure that consumers have access to medically necessary care in the interim. Essentially, this provision creates a temporary presumption in favor of the treating physician's judgment in prescribing the medication. We urge its passage.

In sum, we strongly urge the passage of Bill No. 5486 and SB 410, but strongly oppose Bill No. 5485 as it pertains to the Basic Health Program, and urge the Committee to task the Health Insurance Exchange Board, in consultation with all stakeholders, to study and make a recommendation to this Committee regarding the choice of a benchmark plan to serve as the Essential Health Benefits package – one of the most important decisions the State will make in implementing the ACA.

Thank you.